Kansas Medical Assistance Program

HEALTHCONNECT Kansas

From the office of the Fiscal Agent

Provider Line: **1-800-933-6593**
Consumer Line: **1-800-766-9012**

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

Botulinum Toxin Type A (Botox®) /OnabotulinumtoxinA(Botox®)
Botulinum Toxin Type B/RimabotulinumtoxinB (Myobloc®)
Prior Authorization Request Form

Beneficiary Name:_____

Beneficiary Medicaid ID #: _____ Date Of Birth:____/_____/_____

Pharmacy Name:_____

Pharmacy Medicaid ID #: _____ Pharmacy NPI#: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Drug Name: _____ NDC Requested: _____

- OR -

Billing Provider's Name (Physicians **OR** Facility): _____

Provider Medicaid ID#: _____ Provider NPI#: _____

Phone Number: (_____)_____ Fax Number: (_____)_____ _____

Procedure code requesting: _____ Total # of units requesting per 6 months: _____

Please indicate the diagnosis and severity for which Botulinum Toxin Type A or Type B is being Prescribed (no dx codes):

_____

_____

_____

Please note: NOT APPROVED FOR COSMETIC PURPOSES.

Prescribing Physician's Signature: _____ Date: ___/___/_____

Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.